Home and Community Based Services Billing Manual

Children's Home and Community Based Services (CHCBS), Children with Life Limiting Illness (CLLI) Children with Autism (CWA)

Home and Community Based Services (HCBS) Overview

Children's Home and Community Based Services (CHCBS) Waiver

Children with a Life Limiting Illness (CLLI) Waiver

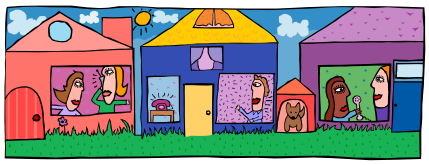
Children with Autism (CWA) Waiver

Medicaid is a health care program for low income Coloradans. Applicants must meet eligibility criteria for one of the Medicaid Program categories in order to qualify for benefits. Major program categories include:

- Aid to Families with Dependent Children/Medicaid Only
- Aid to the Needy Disabled
- Baby Care/Kids Care
- Colorado Works/TANF (Temporary Assistance for Needy Families)
- Aid to the Blind
- Old Age Pension

Waiver programs provide additional Medicaid benefits to specific populations who meet special eligibility criteria.

Level of care determinations are made annually by the case management agencies (aka Single Entry Points and Community Center Boards). Members must meet financial, medical, and program criteria to access services under a waiver. The applicant must be at risk of placement in a nursing facility, hospital, or ICF/IID (intermediate care facility for Individuals with an Intellectual Disability). To utilize waiver benefits, members must be willing to receive services in their homes or communities. A member who receives services through a waiver is also eligible for all basic Medicaid covered services except nursing facility and long-term hospital care. When a member chooses to receive services under a waiver, the services must be provided by certified Medicaid providers or by a Medicaid contracting managed care organization (MCO).



Each waiver has an enrollment limit. Applicants may apply for more than one waiver, but may only receive services through one waiver at a time.

Prior Authorization Requests (PARs)

Unless otherwise noted, all HCBS services require prior approval before they can be reimbursed by the Colorado Medical Assistance Program. Case Management Agencies (CMA) complete the Prior Approval and/or Cost Containment requests for their specific programs according to instructions published in the regulations for the Department of Health Care Policy and Financing (the Department).

Providers may contact the CMA for the status of the PAR or inquire electronically through the Colorado Medical Assistance Program Web Portal.

The CMAs responsibilities include, but are not limited to:

- Informing members and/or legal guardian of the eligibility process.
- Submitting a copy of the approved Enrollment Form to the County department of human/social services for a Colorado Medical Assistance Program member identification number.
- Developing the appropriate Prior Approval and/or Cost Containment Record Form of services and projected costs for approval.
- Submitting a copy of the Prior Authorization and/or Cost Containment document to the authorizing agent. A list of authorizing agents can be found in Appendix D of the Appendices in the Provider Services Billing Manuals section.
- Assessing the member's health and social needs.
- Arranging for face-to-face contact with the member.
- Monitoring and evaluating services.
- Reassessing each member annually or upon change in condition.
- Demonstrating continued cost effectiveness whenever services increase or decrease.

Approval of prior authorization does not guarantee Colorado Medical Assistance Program

payment and does not serve as a timely filing waiver. Prior authorization only assures that the approved service is a medical necessity and is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, provider information completed appropriately, required attachments included, etc.) before payment can be made.

Prior approvals must be completed thoroughly and accurately. If an error is noted on an approved request, it should be brought to the attention of the member's case manager for corrections. Procedure codes, quantities, etc., may be changed or entered by the member's case manager.

The authorizing agent or CMA is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

PAR Submission

The following PAR (CHCBS, CLLI, and CWA) forms are fillable electronically and are located in the Provider Services Forms section of the Department's website. The use of the forms is strongly encouraged due to the complexity of the calculations.

Send all New, Continued Stay Reviews (CSR), and Revised PARs for CHCBS, CLLI, and CWA to the Department's fiscal agent:

Xerox State Healthcare
PARs
P.O. Box 30
Denver, CO 80201-0030

Note: If submitted to the Department's fiscal agent, the following correspondence will not be returned to case managers, outreach will not be performed to fulfill the requests, and all such requests will be recycled: 1) Paper PAR forms that do not clearly identify the case management agency in the event the

form(s) need to be returned and/or 2) PAR revision requests not submitted on Department approved PAR forms, including typed letters with revision instructions. Should questions arise about what fiscal agent staff can process, please contact the appropriate Department Waiver manager.

PAR Form Instructional Reference Table

Field Label	Completion Format	Instructions
PA Number being revised		Conditional Complete if PAR is a revision. Indicate original PAR number assigned.
Revision	Check box ☐ Yes ☐ No	Required Check the appropriate box.
Client Name	Text	Required Enter the member's last name, first name and middle initial. Example: Adams, Mary A.
Client ID	7 characters, a letter prefix followed by six numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456
Sex	Check box ☐ M ☐ F	Required Check the appropriate box.
Birthdate	6 numbers (MM/DD/YY)	Required Enter the member's birth date using MM/DD/YY format. Example: January 1, 2010 = 01/01/10.
Requesting Provider #	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
Client's County	Text	Required Enter the member's county of residence
Case Number (Agency Use)	Text	Optional Enter up to 12 characters, (numbers, letters, hyphens) which helps identify the claim or member.
Dates Covered (From/Through)	6 numbers for from date and 6 numbers for through date (MM/DD/YY)	Required Enter PAR start date and PAR end date.

Field Label	Completion Format	Instructions
Services Description	Text	N/A List of approved procedure codes for qualified and demonstration services.
Provider	Text	Optional (CMA use) Enter up to 12 characters to identify provider.
Modifier	2 Letters	Required The alphanumeric values in this column are standard and static and cannot be changed.
Max # Units	Number	Required Enter the number of units next to the services being requested for reimbursement.
Cost Per Unit	Dollar Amount	Required Enter cost per unit of service.
Total $ Authorized	Dollar Amount	Required The dollar amount authorized for this service automatically populates.
Comments	Text	Optional Enter any additional useful information. For example, if a service is authorized for different dates than in "Dates Covered" field, please include the HCPCS procedure code and date span here.
Total Authorized HCBS Expenditures	Dollar Amount	Required Total automatically populates.
Number of Days Covered	Number	Required The number of days covered automatically populates.
Average Cost Per Day	Dollar Amount	Required The member's maximum authorized cost divided by number of days in the care plan period automatically populates.
Immediately prior to HCBS enrollment, this client was in one of the following facility types:	Check box ☐ Nursing Facility ☐ Hospital	Required for CHCBS only Check the appropriate box.

Field Label	Completion Format	Instructions
Case Manager Name	Text	Required Enter the name of the Case Manager.
Case Manager Signature	Text	Required Signature of Case Manager.
Agency	Text	Required Enter the name of the case management agency.
Phone #	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager.
Email	Text	Required Enter the email address of the Case Manager.
Date	6 Numbers (MM/DD/YY)	Required Enter the date completed.

HCBS-CHCBS PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR CHILDREN HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT — CHCBS-U5

HCBS - Children's Home and Community Based Services (CHCBS) Waiver

PA Number being revised:

Revision? ☐ Yes ☑ No

1. CLIENT NAME		2. CLIENT ID	3. SEX	4. BIRTHDATE	
Client, Ima		A11111	☐ M ☑ F	7/7/2007	
5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED		
00112233			From: 07/05/13	Through:	07/04/14

STATEMENT OF REQUESTED SERVICES

	9. Description	10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
	T1016 CHCBS Case Management (U5)			90	$8.43	$758.70	
	H0038 IHHS Health Maintenance Activities (U5)			4928	$7.09	$34,939.52	
A							
B							

16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)	$35,698.22
17. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)	365
18. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)	$97.80
A. Monthly State Cost Containment Amount	$0.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling	$0.00

19. Immediately prior to HCBS enrollment, this client was in one of the following facility types: ☐ Nursing Facility ☑ Hospital

20. CASE MANAGER NAME	21. AGENCY	22. PHONE #	23. EMAIL	24. DATE
Jane Doe	AAA	333-111-2222	Jane.Doe@AAA.com	7/15/2013
20A. CASE MANAGER SIGNATURE: *Jane Doe*				

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

25. CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

26. REGULATION(S) upon which Denial or Return is based:

27. DEPARTMENT APPROVAL SIGNATURE: 28. DATE:

HCBS-CLLI PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR CHILDREN HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT — CLLI-UD

HCBS - Children with Life Limiting Illness (CLLI) Waiver

PA Number being revised:

Revision? ☐ Yes ☑ No

1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTH DATE
Client, Ima	1212121	☑ M ☐ F	1/1/2010

5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED	
0101010101	Jefferson		From: 06/01/14	Through: 05/31/15

STATEMENT OF REQUESTED SERVICES

9. Description	10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
H2032 Art and Play Therapy (UD)		HA	30	$15.41	$462.30	
H2032 Art and Play Therapy Group (UD)						
H2032 Music Therapy (UD)						
H2032 Music Therapy Group (UD)		HQ	30	$8.63	$258.90	
97124 Massage Therapy (UD)						
G9012 Care Coordination (UD)						
S9123 Pain and Symptom Management (UD)						
S5150 Respite Care - Unskilled (4 hours or less) (UD)						
S5151 Respite Care - Unskilled (4 hours or more) (UD)						
T1005 Respite Care - CNA (4 hours or less) (UD)						
S9125 Respite Care - CNA (4 hours or more) (UD)						
T1005 Respite Care - Skilled RN, LPN (4 hours or less) (UD)						
S9125 Respite Care - Skilled RN, LPN (4 hours or more) (UD)						
S0257 Bereavement Counseling (UD)						
S0257 Therapeutic Life Limiting Illness Support - Individual (UD)						
S0257 Therapeutic Life Limiting Illness Support - Family (UD)						
S0257 Therapeutic Life Limiting Illness Support - Group (UD)						
A						
B						

16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)	$721.20
17. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)	365
18. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)	$1.98
A. Monthly State Cost Containment Amount	$0.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling	$0.00

19. CASE MANAGER NAME	20. AGENCY	21. PHONE #	22. EMAIL	23. DATE
John Doe				
19A. CASE MANAGER SIGNATURE: *John Doe*	BBB	222-111-4444	John.Doe@BBB.com	6/2/2013

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

24. CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction - Date:

25. REGULATION(S) upon which Denial or Return is based:

26. DEPARTMENT APPROVAL SIGNATURE: 27. DATE:

HCBS-CWA PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR CHILDREN HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT

CWA-LL

PA Number being revised:

Revision? ☐ Yes ☑ No

HCBS - Children with Autism (CWA) Waiver

1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE
Client, Ima	A4444444	☐ M ☑ F	10/1/2010

5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED	
			From:	Through:
5555555555	Adams		07/01/13	06/30/14

STATEMENT OF REQUESTED SERVICES

9. Description	10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments
H0004 Behavior Therapies, Lead Therapist (UL)			196	$23.31	$4,568.76	
H0004 Behavior Therapies, Senior Therapist (UL)		HN	1600	$12.14	$19,424.00	
H2019 Behavior Therapies, Line Staff (UL)						
H2000 Ongoing Treatment Evaluations (UL)						
H2000 Post Service Evaluation (UL)		TS				
A						
B						

16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)	$23,992.76
17. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)	365
18. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)	$65.73
A. Monthly State Cost Containment Amount	$0.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling	$0.00

19. CASE MANAGER NAME	20. AGENCY	21. PHONE #	22. EMAIL	23. DATE
Jane Doe	CCC	111-222-3333	Jane.Doe@CCC.com	7/1/2014
19A. CASE MANAGER SIGNATURE: *Jane Doe*				

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

24. CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

25. REGULATION(S) upon which Denial or Return is based:

26. DEPARTMENT APPROVAL SIGNATURE: 27. DATE:

Claim Submission

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Department's fiscal agent, Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090.

The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires approval)
- Claims that, by policy, require attachments
- Reconsideration claims

For more detailed CMS 1500 billing instructions, please refer to the CMS 1500 General Billing Information manual in the Provider Services Billing Manuals section.

Electronic Claims

Instructions for completing and submitting electronic claims are available through the 837 Professional (837P) Web Portal User guide via the Web Portal and also on the Department's Colorado Medical Assistance Program Web Portal page.

Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required."

The Special Program Indicator (SPI) must be completed on claims submitted electronically. Claims submitted electronically and on paper are identified by using the specific national modifiers along with the procedure code. The appropriate procedure codes and modifiers for each HCBS waiver are noted throughout this manual. When the services are approved, the claim may be submitted to the Department's fiscal agent. For more detailed billing instructions, please refer to the CMS 1500 General Billing Information in the Provider Services Billing Manuals section.

Procedure/HCPCS Codes Overview

The Department develops procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used to submit claims for services provided to Colorado Medical Assistance Program members. The procedure codes represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA).

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. These include ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME/Supplies) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits. CPT codes are identified using 5 numeric digits.

Children's Home and Community Based Services (CHCBS)

The Children's Home and Community Based Services (CHCBS) waiver program is for disabled children who are at risk of institutionalization in a hospital or nursing facility. These children would not otherwise qualify for Colorado Medical Assistance due to parental income and/or resources. All state plan Colorado Medical Assistance benefits and case management are provided to children birth through age 17. The children must meet the established minimum criteria for hospital or nursing facility level of care. Members meeting program eligibility requirements are certified as medically eligible for CHCBS by the case manager.

CHCBS Procedure Code Table

Providers may bill the following procedure codes for HCBS-CHCBS services:

HCBS-CHCBS Procedure Code Table (Special Program Code 88)			
Case Management (HCBS – CM)			
Description	**Procedure Code + Modifier(s)**		**Units**
Case Management	T1016	U5	1 unit = 15 minutes

In-Home Support Services (IHSS)

IHSS is limited to health maintenance activities, which include support for activities of daily living or instrumental activities of daily living. Additionally, IHSS providers must provide core independent living skills.

HCBS-CHCBS Procedure Code Table (Special Program Code 88)			
In-Home Support (HCBS-IHSS)			
Description	**Procedure Code + Modifier(s)**		**Units**
Health Maintenance Activities	H0038	U5	1 unit = 15 minutes

CHCBS, CLLI, and CWA Paper Claim Reference Table

The following paper form reference table gives required and/or conditional fields for the paper CMS 1500 claim form for HCBS-CHCBS, CLLI, and CWA claims:

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.

CMS Field #	Field Label	Field is?	Instructions
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Not Required	
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Not Required	
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Not Required	
9a	**Other Insured's Policy or Group Number**	Not Required	
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
10a-c	**Is Patient's Condition Related to?**	Not Required	
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Not Required	
11a	**Insured's Date of Birth, Sex**	Not Required	
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another** Health **Benefit** Plan**?**	Not Required	
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Not Required	
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
17	**Name of Referring Physician**	Not Required	
18	**Hospitalization Dates Related to Current Service**	Not Required	
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM **HCBS** CHCBS and CLLI may use 799.9 CWA must use 299.00
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Not Required	**HCBS** Leave blank
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the

CMS Field #	Field Label	Field is?	Instructions
			additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014 From To 01 01 14		| Or From To 01 01 14 01 01 14 Span dates of service From To 01 01 14 01 31 14 <u>Single Date of Service</u>: Enter the six digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. <u>Span billing</u>: permissible if the same service (same procedure code) is provided on consecutive dates.
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 03 School 11 Office 12 Home 34 Hospice
24C	**EMG**	Not Required	

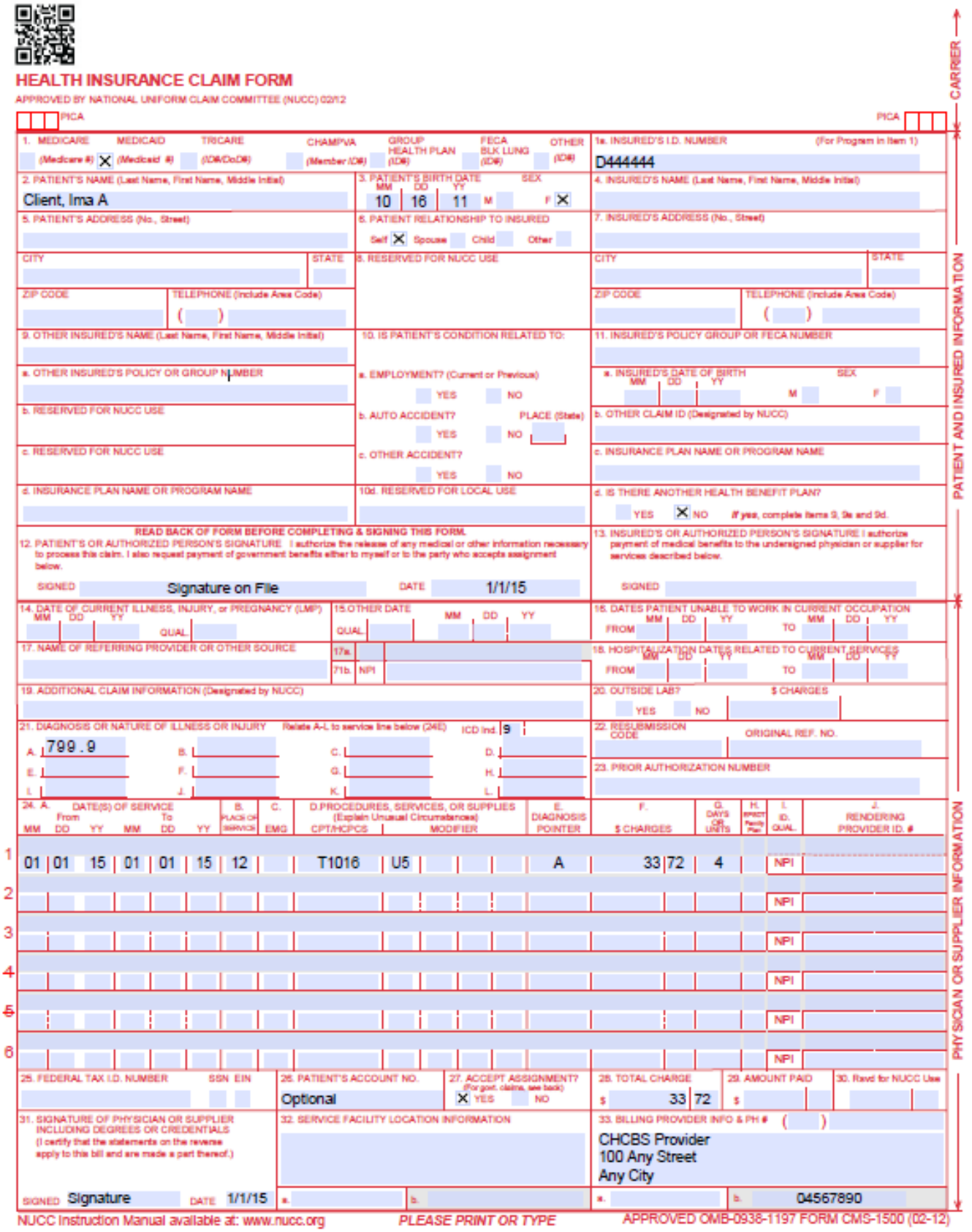
CMS Field #	Field Label	Field is?	Instructions
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. **HCBS** Refer to the CHCBS, CLLI or CWA procedure code tables.
24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. **HCBS** Refer to the CHCBS, CLLI or CWA procedure code tables.
24E	Diagnosis **Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial

CMS Field #	Field Label	Field is?	Instructions
			insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units. **Home & Community Based Services** Combine units of services for a single procedure code for the billed time period on one detail line. Dates of service do not have to be reported separately. Example: If forty units of personal care services were provided on various days throughout the month of January, bill the personal care procedure code with a From Date of 01/03/XX and a To Date of 01/31/XX and 40 units.
24H	**EPSDT/Family Plan**	Not Required	**EPSDT** (shaded area) Not Required **Family Planning** (unshaded area) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Not Required	
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).

CMS Field #	Field Label	Field is?	Instructions
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Not Required	
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Not Required 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

CMS 1500 CHCBS Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 11 SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES | NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE: 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 799.9 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 15	01 01 15	12		T1016	U5			A	33 72	4		NPI	
2													NPI	
3													NPI	
4													NPI	
5													NPI	
6													NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE $ 33 72

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION a. | b.

33. BILLING PROVIDER INFO & PH # ( )

CHCBS Provider
100 Any Street
Any City

a. | b. 04567890

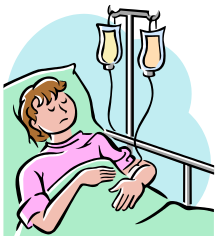
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Home and Community Based Services for Children with Life Limiting Illness (CLLI)



The Home and Community Based Services for Children with Life Limiting Illness (CLLI) Waiver formerly known as the Pediatric Hospice Waiver (PHW) is for children from birth through age 18 with a medical diagnosis of a life-limiting illness who meet the institutional level of care for inpatient hospitalization. Level of care determinations are conducted annually by the single entry point case management agencies. Services include Bereavement Counseling, Expressive Therapy (Art, Play, and Music), Massage Therapy, Palliative/Supportive Care (Care Coordination and Pain and Symptom Management), Respite Care, and Therapeutic Life Limiting Illness Support Services. Members that are enrolled in the waiver also have access to all state plan Colorado Medical Assistance benefits, including curative care. There is no requirement for a nine-month terminal prognosis.

HCBS-CLLI Procedure Code Table

Providers may bill the following procedure codes for HCBS-CLLI services**:**

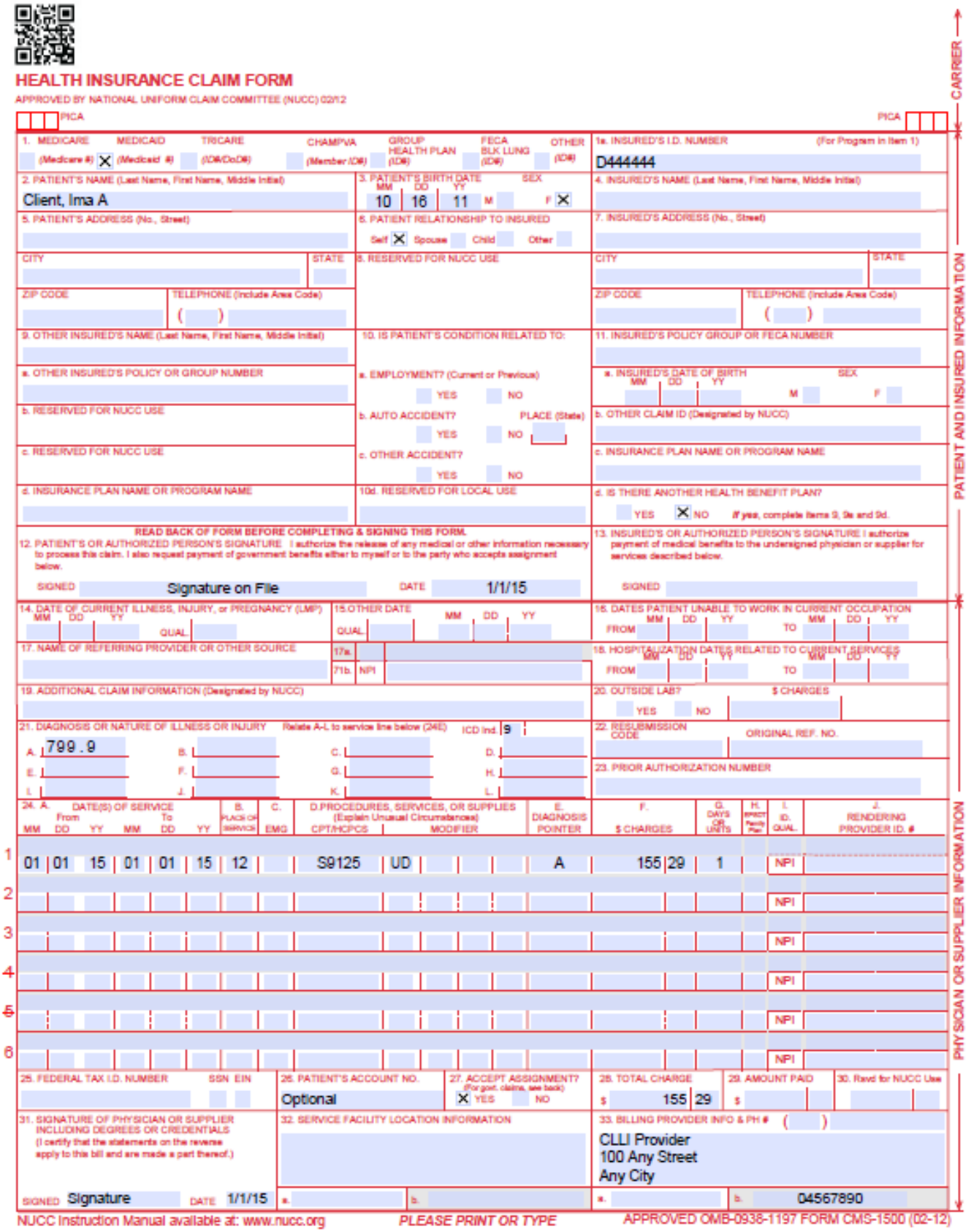
HCBS-CLLI Procedure Code Table (Special Program Code 97)				
Description	**Procedure Code + Modifier(s)**		**Place of Service**	**Units**
Art and Play Therapy	H2032	UD, HA	11 - Office 12 - Home	1 unit = 15 minutes
Art and Play Therapy - Group	H2032	UD, HA, HQ	11 - Office 12 - Home	1 unit = 15 minutes
Music Therapy	H2032	UD	11 - Office 12 - Home	1 unit = 15 minutes
Music Therapy - Group	H2032	UD, HQ	11 - Office 12 - Home	1 unit = 15 minutes
Massage Therapy	97124	UD	11 - Office 12 - Home	1 unit = 15 minutes
Care Coordination	G9012	UD	11 - Office 12 - Home	1 unit = 15 minutes
Pain and Symptom Management	S9123	UD	12 – Home 11 - Office 34 - Hospice	1 unit = 1 hour
Respite Care – Unskilled (4 hours or less)	S5150	UD	12 - Home	1 unit = 15 minutes

HCBS-CLLI Procedure Code Table (Special Program Code 97)				
Description	**Procedure Code + Modifier(s)**		**Place of Service**	**Units**
Respite Care – Unskilled (4 hours or more)	S5151	UD	12 - Home	1 unit = 1 day
Respite Care – CNA (4 hours or less)	T1005	UD	12 - Home	1 unit = 15 minutes
Respite Care – CNA (4 hours or more)	S9125	UD	12 - Home	1 unit = 1 day
Respite Care - Skilled RN, LPN (4 hours or less)	T1005	UD, TD	12 - Home	1 unit = 15 minutes
Respite Care - Skilled RN, LPN (4 hours or more)	S9125	UD, TD	12 - Home	1 unit = 1 day
Bereavement Counseling	S0257	UD, HK	12 – Home 11 - Office	1 unit = lump sum
Therapeutic Life Limiting Illness Support – Individual	S0257	UD	12 – Home 11 - Office	1 unit = 15 minutes
Therapeutic Life Limiting Illness Support – Family	S0257	UD, HR	12 – Home 11 - Office	1 unit = 15 minutes
Therapeutic Life Limiting Illness Support - Group	S0257	UD, HQ	12 – Home 11 - Office	1 unit = 15 minutes

Service Limitations

Reimbursement for HCBS-CLLI Therapeutic Life Limiting Illness Support services (S0257 with any "UD" modifier) shall be limited to 98 hours per annual certification. Reimbursement for HCBS-CLLI respite care services (T1005, S9125, S5150 and S5151) shall be limited to 30 days (unique dates of service) per annual certification. Reimbursement for HCBS-CLLI respite care services (T1005, S9125, S5150 and S5151) shall not be duplicated at the same time of service as state plan Home Health or Palliative/Supportive Care services (S9123) and shall be denied. Expressive Therapy (H2032 – Art, Play, and Music) is limited to 39 hours per annual certification. Massage Therapy (97124) is limited to 24 hours per annual certification.

CMS 1500 HCBS-CLLI Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 11 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 799.9 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	15	01	01	15	12		S9125	UD	A	155 29	1		NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 155 29

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CLLI Provider
100 Any Street
Any City

a. b. 04567890

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Home and Community Based Services for Children with Autism (HCBS-CWA)

The Home and Community Based Services for Children with Autism (HCBS-CWA) waiver program is for

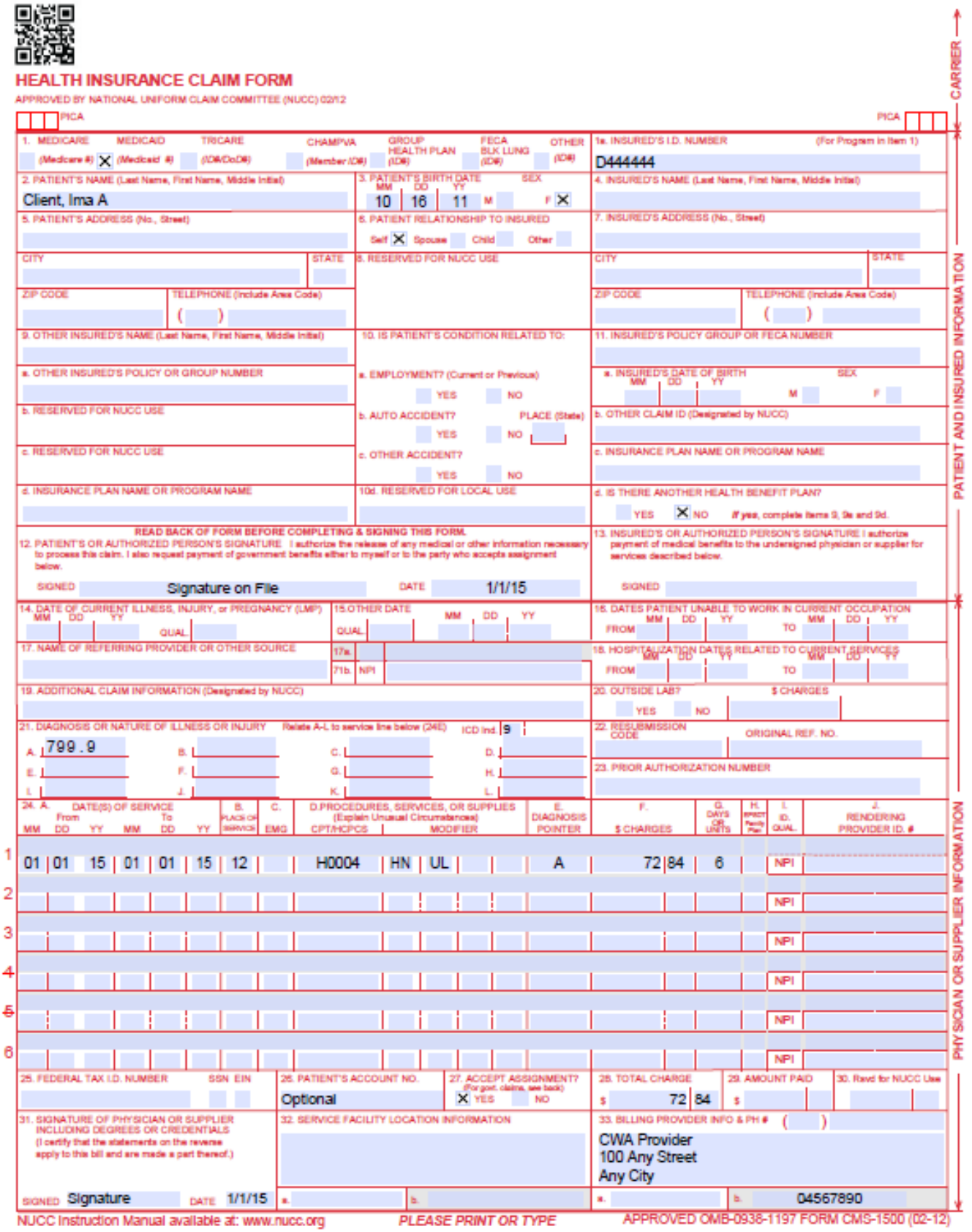
children from birth to age six (6) with a medical diagnosis of Autism. The children must meet the institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID). Level of care determinations are made annually by the case management agency. Eligible children qualify for behavioral therapies provided through the waiver as well as for all state plan Colorado Medical Assistance benefits. Note: There is a limit of $25,000 annually per child for CWA services.

HCBS-CWA Procedure Code Table

Providers may bill the following procedure codes for HCBS-CWA services:

HCBS-CWA Procedure Code Table (Special Program Code 96)			
Description	**Procedure Code + Modifier(s)**		**Units**
Behavioral Therapies, Lead Therapist	H0004	UL	1 unit = 15 minutes
Behavioral Therapies, Senior Therapist	H0004	UL, HN	1 unit = 15 minutes
Behavioral Therapies, Line Staff	H2019	UL	1 unit = 15 minutes
Initial/ Ongoing Treatment Evaluation	H2000	UL	1 unit = 15 minutes
Post Service Evaluation	H2000	UL, TS	1 unit = 15 minutes

CMS 1500 HCBS-CWA Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 11 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 799.9 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 15	01 01 15	12		H0004	HN UL		A	72 84	6		NPI	
2												NPI	
3												NPI	
4												NPI	
5												NPI	
6												NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 72 84

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CWA Provider
100 Any Street
Any City

a. b. 04567890

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

11 Other

The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services Billing Manuals section.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➢ *CMS 1500*: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➢ *2006 ADA Dental*: Indicate "LBOD" and the date in box 35 - Remarks
Adjusting Paid Claims	If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider. **Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements. *Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.* **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.

Billing Instruction Detail	Instructions
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied. **Correct the claim errors and refile within 60 days** of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.
Returned Paper Claims	A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information. **Correct the claim errors and re-file within 60 days** of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent. **LBOD** = the stamped fiscal agent date on the returned claim.
Rejected Electronic Claims	An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection. **Correct claim errors and refile within 60 days** of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection. **LBOD** = the date shown on the claim rejection report.
Denied/Rejected Due to Member Eligibility	An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility. **File the claim within 60 days** of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Member Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that: • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.

Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Certification & Request for Timely Filing Extension in the Provider Services Forms section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.* **File the claim within 60 days** of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a

Billing Instruction Detail	Instructions
	denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

HCBS-CHCBS, CWA, and CLLI Specialty Manuals Revisions Log

Revision Date	***Section/Action***	***Pages***	***Made by***
05/07/2013	*Created*	*All*	*jg/cc/sm*
12/31/2013	Added the following services to the CWA waiver: Initial/ Ongoing Treatment Evaluation (H2000) and Post Service Evaluation (H2000)	*25*	*cc*
05/08/2014	*Updated CLLI PAR Example*	*8*	*mm*
05/08/2014	*Updated CWA PAR Example*	*9*	*mm*
05/08/2014	*Updated CLLI Procedure Code Table to account for new 7/1 services. Benefit description and limitations also revised*	*21-22*	*mm*
05/08/2014	*Updated CLLI Claim Example*	*23*	*mm*
05/09/2014	*Updated CWA Units for Post Service Eval. Changed from 1 minutes to 15 minutes*	*24*	*Mm*
8/1/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*
8/1/14	*Updated Professional Claim Billing Instructions section with CMS 1500 information.*		*ZS*
8/1/14	*Changed all references of client to member*	*Throughout*	*ZS*
8/1/14	*Updated all claim examples to the cms 1500*		*ZS*
8/4/14	*Updated all web links to reflect new Department website*	*Throughout*	*Mm*
8/5/14	*Added Expressive Therapy Service Limitations per benefit manager*	*20*	*mm*
8/5/14	*Added CWA limit per benefit manager*	*23*	*mm*
12/8/14	*Removed Appendix H information, added Timely Filing document information*	*28*	*mc*